



**Small Group Proposal  
For**

**xyz**

**June 9, 2009**

**Effective Date: July 1, 2009**

**Proposal Number: 246719**

## Group Summary

**Group Name:** xyz  
**Group Street Address:** , NY 11746  
**Effective Date:** July 1, 2009

**Group BA Name:**  
**Phone Number:**  
**Fax Number:**  
**Proposal Number:** 246719

### Select Plan

Option Number	I	II
<b>Plan Name</b>	NY HMO/Liberty/Gated	Ease/Liberty/Non-Gated
<b>Benefits</b>		
<b>In-Network Copayment</b>	\$30/\$50 w/\$150 OP;\$500/day IP Hosp	\$50/\$50
<b>UCR</b>	N/A	N/A
<b>In-Network Coinsurance %</b>	100%	100%
<b>In-Network Coinsurance Limit</b>	N/A	N/A
<b>In-Network Deductible</b>	N/A	N/A
<b>Out-of-Network Coinsurance %</b>	N/A	N/A
<b>Out-of-Network Coinsurance Limit</b>	N/A	N/A
<b>Out-of-Network Deductible</b>	N/A	N/A
<b>Deductible Accumulation Period</b>	Calendar Year	Calendar Year
<b>Riders</b>		
<b>Pharmacy Rider</b>	15/35/75	15/35/75
<b>Pharmacy Deductible</b>	\$100	\$50
<b>Dental</b>	N/A	N/A
<b>Vision</b>	N/A	N/A
<b>Unlimited Skilled Nursing</b>	N/A	N/A
<b>Inpatient Hospital Rider</b>	N/A	N/A
<b>Complementary and Alternative Medicine</b>	N/A	N/A
<b>Mental Health</b>	N/A	N/A
<b>Dependent Student Cutoff Age</b>	N/A	N/A
<b>Domestic Partner</b>	N/A	N/A
<b>Rates</b>		
<b>Single</b>	\$345.95	\$404.46
<b>Couple</b>	\$761.09	\$889.81
<b>Parent with Children</b>	\$640.01	\$748.26
<b>Family</b>	\$1072.45	\$1253.83
<b>Total Monthly Premium</b>	\$1418.40	\$1658.29
<b>Total Annual Premium</b>	\$17020.80	\$19899.48

**Signature:** \_\_\_\_\_

*Note: All quotes are based on the census data provided. Approval of coverage and final rates will be based on actual enrollment. Please be advised this quote is for informational purposes only. The information contained herein is subject to both state regulatory and Oxford home office approval as appropriate.*

**BENEFIT**

**IN-NETWORK**

**FINANCIAL**

Deductible: Single	None
Family	None
Coinsurance	None
Maximum Out-Of-Pocket: Single	Not Applicable
Family	Not Applicable
Maximum Lifetime Benefit Per Member	Unlimited

**PREVENTIVE CARE**

Adult Preventive Care	No charge
Pediatric Preventive Care	No charge
Infant Preventive Care	No charge
Immunizations	No charge

**OUTPATIENT CARE**

Primary Care Physician office visits	\$30 copay per visit
Specialist office visits	\$50 copay per visit
Surgery**	\$150 copay
Laboratory services	No Charge
Radiology services**	20% coinsurance up to \$100 per procedure

**ALLERGY CARE**

Initial visit, and all subsequent visits	\$50 copay per visit
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**HOSPITAL CARE**

Physician's and surgeon's services **	No Charge
Semi-private room and board **	\$500 per day to a maximum of \$1,000 per continuous confinement
All drugs and medication**	No Charge

**EMERGENCY CARE**

Ambulance Service	No Charge
At hospital Emergency Room (If member is admitted to the Hospital, notification is required)	\$150 copay - Waived if admitted
Emergency Care in Urgi-Center**	\$30 copay per visit

**MATERNITY CARE**

Prenatal and Post-natal care**	\$30 copay per initial visit
Hospital services for mother and child **	\$500 per day to a maximum of \$1,000 per continuous confinement

**SHORT TERM REHABILITATION**

60 consec. Inpatient days per condition per lifetime**	\$500 per day to a maximum of \$1,000 per continuous confinement
60 Outpatient visits per condition per lifetime**	\$50 copay per visit

**HOME HEALTH CARE**

40 visits per Calendar Year**	\$30 copay per visit
Physician house calls	\$30 copay per visit

**SKILLED NURSING FACILITY**

200 days per Calendar Year **	\$500 per day to a maximum of \$1,000 per continuous confinement
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**BENEFIT**

**IN-NETWORK**

**SUBSTANCE ABUSE**

7 days of Inpatient detox. per Calendar Year **	\$500 per day to a maximum of \$1,000 per continuous confinement
30 days of Inpatient rehab. per Calendar Year **	\$500 per day to a maximum of \$1,000 per continuous confinement
60 Outpt rehab. visits per Calendar Year ** (combined w/office visits)	\$30 copay per visit After 52 visits covered at 100%
60 office visits per Calendar Year ** (combined w/outpatient visits)	\$30 copay per visit After 52 visits covered at 100%

**MENTAL HEALTH CARE**

30 days of Inpatient care per Calendar Year **	\$500 per day to a maximum of \$1,000 per continuous confinement
30 Outpatient visits per Calendar Year** (combined w/office visits)	\$50 copay per visit
30 office visits per Calendar Year** (combined w/outpatient visits)	\$50 copay per visit

**PRESCRIPTION DRUGS**

(Includes Oral Contraceptives)

(Includes Oral Contraceptives)	\$100 Deductible (waived for Tier 1 Drugs)
Tier 1***	\$15 copayment
Tier 2***	\$35 copayment
Tier 3***	\$75 copayment

**ALTERNATIVE MEDICINE**

Chiropractic care	\$50 copay per visit
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**HOSPICE CARE (210 days per Calendar Year combined inpatient and outpatient)**

Inpatient	\$500 per day to a maximum of \$1,000 per continuous confinement
Outpatient	\$150 copayment

**OTHER COVERAGE**

Medical Supplies** \$1,500 limit per Calendar Year combined with DME	No Charge
Durable Medical Equipment** \$1,500 limit per Calendar Year combined with Medical Supplies Precertification for items \$500 or more.	No Charge
Exercise Facility Subscriber	\$200 reimbursement per 6 month period
Spouse	\$100 reimbursement per 6 month period

**DEPENDENT ELIGIBILITY:**

Eligible dependents include the employee's spouse and dependent children until the child reaches age 19, or age 23 if a full time student. Benefits discontinue at the end of the Calendar Year.

\*\* These services require **precertification** through Oxford. You must call Oxford at 800-444-6222 at least 14 days in advance of request.

Mental health and substance abuse services can be precertified through Oxford's Behavioral Health Department by calling 1-800-201-6991.

\*\*\*Prescription medication ordered through the Mail Order Drug Program are subject to 2 applicable retail pharmacy copays.

The Prescription Drug Benefit is based on a Per Contract Year Limit for any applicable deductibles and/or maximum limits.

**Please Note: This sample summary of coverage is provided for informational purposes only. The applicable Summary of Benefits will be issued to eligible enrolled members as part of the Certificate of Coverage. Coverage is subject to the terms and conditions of the Certificate.**

Refer to your Certificate of Coverage for a more complete listing of all benefits, limitations, and exclusions which include, among other services not authorized by Oxford, cosmetic surgery, routine foot care, custodial care, personal comfort or convenience items, private or special duty nursing, learning and behavioral disorders, Worker's Compensation, military service-related conditions, hearing aids, or, unless otherwise stated, dental services, and vision correction services and supplies.

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**BENEFIT**

**IN-NETWORK**

**FINANCIAL**

Deductible: Single	None
Family	None
Coinsurance	None
Maximum Out-Of-Pocket: Single	None
Family	None
Maximum Lifetime Benefit Per Member	Unlimited

**PREVENTIVE CARE**

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Semi-private room and board **	\$500 per day, to \$2,500 per calendar year
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